EXAMINATION AUTHORIZATION/INVOICE FOR SERVICES

5. STATE OF MICHIGAN DEPARTMENT OF HUMAN SERVICES LOCAL OFFICE ADDRESS

6. **PROVIDER/VENDOR ADDRESS**

1. INVOICE NUMBER
2. Canceled-Void Invoice ☐
3. Missed Appt. (not paid) ☐
4. Date of Service (Authorization Date)

7. INSTRUCTIONS TO PROVIDER/VENDOR: Notify DHS at once if patient(s) fails to appear. **Missed appointments and unauthorized tests will not be covered. Retain a copy of this Invoice, with the Invoice Number in Item 1, for payment reconciliation. Provider/Vendor completes Item 13 for no more than 2 different services for the patient indicated. A separate invoice must be completed if more than 2 services are needed or if services for a patient differ from those indicated in Item 10. Provider/Vendor may also enter the Patient Account number in Item 14 for each patient.** Amounts billed for the items listed in Item 10 must be the lower of either the DHS Fee Schedule Maximum, Item 12 (page 2), or your usual, customary and reasonable charge for the service.

I certify the goods/services shown below were provided and that I did not and will not make any charge or accept any payment from the client or his family for the services provided on this authorization. I further certify that all services were rendered without regard to any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. Return signed Provider/Vendor Invoice with the DHS-93, or the signed DHS-93, with your report to the address in Item 5 above.

8. PROVIDER/VENDOR TO COMPLETE

a. FE ID No. Do not use Provider No.	b. Soc. Sec. No. Do not use Provider No.	c. MAIN Mail Code	d. Provider/Vendor Phone Number
e. Payee Name corresponding to FE ID No (if other than above)	f. Billing Address (if other than 6 above)		
g. Provider/Vendor Signature		h. Date Signed	

9. SERVICE WORKER TO COMPLETE (Patient/Recipient information on next page)

a. Grantee Name (Client Name if not grantee)	b. Case Number	c. County	d. District	e. Section	f. Unit	g. Worker
h. Provider/Vendor Name		i. Provider/Vendor Number (not FE ID or SSN)				
j. Service Worker Name		k. Service Worker Phone Number				

10. DESCRIPTION OF SERVICES AUTHORIZED

a. Children's Foster Care (CFC), Child Protective Services (CPS), Juvenile Justice Services (JJS) and Preventive Services for Families (PSF)

☐ Medical ☐ Psychiatric ☐ Substance Abuse Screening and Assessment
☐ Child Sexual Abuse Exam ☐ JJS Blood Drawing for DNA Gene Coding
☐ Psychological ☐ CPS Second Opinion

Explain:

b. ☐ APS ☐ CFC ☐ CPS ☐ **JJS** ☐ **PSF**

☐ **Photostat Copies of Existing Medical Records -** **VENDOR SPECIFY NUMBER OF COPIES**

c. **Adult Protective Services:**
☐ Medical ☐ Psychological ☐ Geriatric Assessment

☐ d. Medical Exam Report Completed from Existing Records
☐ APS ☐ CFC ☐ CPS ☐ JJS ☐ PFS

e. Other (Specify below) ☐ APS ☐ CFC ☐ CPS ☐ JJS ☐ PFS

11. Service Worker to complete upon return from Provider/Vendor

a. Service Worker Approval - Requested Reports Received ☐ Yes		b. Date:	
c. Service Worker Signature	d. Date	e. Supervisor Signature	f. Date

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 280 of 1939, Federal CFR, and 45 CFR.
COMPLETION: Mandatory.
PENALTY: Department is unable to pay for medical services and materials.

DISTRIBUTION:
Original to Provider/Vendor
Original to Local Fiscal Office after return from Provider/ Vendor
Case Record Copy

EXAMINATION AUTHORIZATION/INVOICE FOR SERVICES

12. FEE SCHEDULE MAXIMUM						13. PROVIDER/VENDOR COMPLETE AMOUNT BILLED	
Service	Exceeds Fee	Yes	Service	Exceeds Fee	Yes	Service 1	Service 2
1	Schedule Maximum Of	☐ No ☐	2	Schedule Maximum Of	☐ No ☐		

14. Patient/Recipient Information

Patient/Recipient 1

a. Patient/Recipient Name	b. Recipient ID Number	c. **Invoice Number**	d. Patient Account Number

e. Program Pay Code:		f. Reason Code:		g. Service Code:		h. Transaction Number:
1.	2.	1.	2.	1.	2.	